Supplement 3: GAD management considerations for perinatal populations

This supplement addresses the principles of care for pregnant and postpartum women. As an additional and practical resource for primary and generalist care, the principles presented here are not exhaustive of the subject matter, acknowledging that healthcare professionals in these settings may also refer or co-manage with specialists, as required.

Pregnant and postpartum women

Assessment

- Assessment tools can inform the need for further evaluation, such as GAD-2 and GAD-7 scales, or the Edinburgh Postnatal Depression Scale (which contain questions on anxiety and thoughts of self-harm).[63]
- DSM or ICD criteria informs the diagnosis of GAD,[63] acknowledging that some symptoms can be challenging to distinguish from pregnancy-related features (e.g. fatigue, irritability, sleep disturbances). Worry can often include concerns for the baby/child, partner, and/or their own wellbeing.[64]
- In addition to typical mental state assessments for adults, additional factors for management planning include impact on mother-child bonding, obstetric health, breastfeeding status, risk of harm to self and others, experience of pregnancy/parenting (including specific stressors), social or partner support, and caregiving responsibilities.[63]

Principles of management for patients with a diagnosis of GAD (if managing in primary or generalist care)

- For patients at mild severity, prioritise psychoeducation, addressing stressors and sleep disturbances, and psychological treatments.[65–67]
- For patients at higher severity, optimise decision-making by discussing treatment options, including medications (if used, note that international guidelines recommend SSRIs) and seeking specialist advice or referral.
- For patients already on existing medication for anxiety disorders, the risk of relapse or deterioration should be considered in deciding on the treatment strategy.

Considerations for use of antidepressants in perinatal GAD

	Benefits	Risks
Pregnancy	Relieve symptoms and improve functioning (limited direct evidence of efficacy,[68,69] extrapolated from the general adult population) Antenatal anxiety is associated with adverse outcomes such as postpartum depression,[70] and child behavioural and emotional symptoms.[71,72]	Individualised risk assessment is advised, given the uncertain and low-quality evidence.[68,73,74] Possible maternal and fetal adverse effects of SSRIs (e.g. postpartum haemorrhage, pre-term birth, poor neonatal adaptation syndrome) should be discussed with the patient, including the absolute risk (which can be low or rare).§
Postpartum	Relieve symptoms and improve functioning (limited direct evidence of efficacy,[68,69] extrapolated from the general adult population) Pospartum anxiety is associated with impaired maternal-infant bonding.[75]	In women who breastfeed, medication with minimal passage into breastmilk is preferred to reduce any adverse effects.** Sertraline is generally considered safe for breastfeeding.[76,77]

§ Whilst not developed specifically for the local population, references such as UK Teratology Information Service (UKTIS) and MotherToBaby may facilitate patient education and discussion.

** Overseas references such as MotherToBaby and LactMed may facilitate patient education and discussion on breastfeeding safety.

Clinical and community resources

Non-pharmacological and pharmacological interventions tailored for the perinatal population are available in tertiary care settings, such as:

- The National University Hospital Women's Emotional Health Service
- KK Women's and Children's Hospital
- Institute of Mental Health

In addition to the Expert Group, the following perinatal psychiatry expert advisers generously contributed their insights and reviewed this supplement:

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Consider specialist involvement